

REINSURANCE HOT NEWS

November 1, 2007

2008 Reinsurance Workshop

Reinsurance Action Request Form

R600

Medicare Coverage Indicated but not Billed

Summary of October Encounter Processing

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2008 Reinsurance Workshop

Mark your calendars the
2008 Reinsurance Workshop has been
scheduled for,

Thursday March 27th, 2008,
AHCCCS 701 East Jefferson
Gold Room 701-3
8:30-2:00
Phoenix, Arizona



Reinsurance Action Request Form

Effective with action requests dated 11/05/07, please submit all research requests on the new form now available on the web. The new form requires a more detailed description of your request. We are requesting you provide the dollar outcome of your request. This dollar amount will need to be net of all discounts/penalties, Medicare information, and subcap code consideration. We will now prioritize each Contractor's requests considering the dollar outcome furnished. Fields on the form appear small but will justify when populated. We ask that you do not reformat the current form.

<http://www.ahcccs.state.az.us/PlansProviders/Forms.asp>

R600

Medicare Coverage Indicated but not Billed



In an attempt to verify Reinsurance reimbursement, we found it necessary to adjust the logic for Edit R600 Medicare Coverage Indicated but not Billed.

The R600 Edit "Medicare Coverage Indicated but Not Billed" has been changed for RI-Encounters (Claim Type 'R'). Regular encounters (Claim Type 'E') will pass through R600 as before prior to associating to a reinsurance case.

Previously RI-Encounters would only fail edit R600 when the Medicare Approved (MDC-APP) and Medicare Paid (MDC-PAID) fields were blank. The edit has now been changed to fail R600 not only when both the MDC-APP and MDC-PAID are spaces but also when both contain a zero.

Coding changes have been made on EC205 for the Medical Form Type 'A' and on EC215 for the Drug Form Type 'C'. The Edit Status Table (EC710) does not contain a value for R600 on the Drug form type.



Summary of October Encounter Processing

In an effort to keep all AHCCCS PMMIS External Users aware of processes that may affect them, attached is a recent email from Data Analysis and Research Manager, Lori Petre. With the implementation of the Foresight Validator we in the Reinsurance hope to receive, less pends.

From: Petre, Lori
Sent: Friday, October 26, 2007 1:13 PM
Subject: Summary of October Encounter Processing

As previously shared AHCCCS Encounter implemented two major and progressive changes in conjunction with October 2007 Encounter processing. These changes included the implementation of the Foresight Validator for inbound Encounter 837 and NCPDP transactions, and the initiation of two Encounter processing cycles per calendar month.

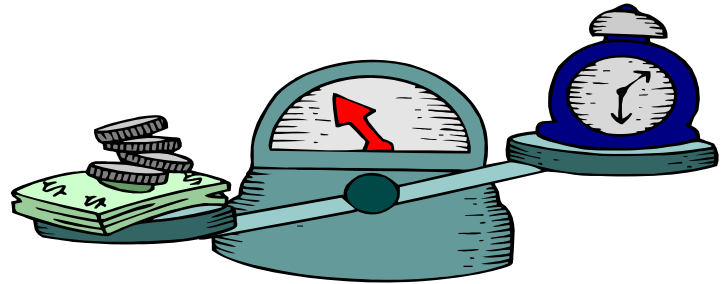
Outlined below are several statistics associated with the October processing:

Validator worked as expected. Files passed through validator and translator within two days for the first cycle and within one day for the second cycle. Top validation errors were X12 submitter and payer IDs, and balancing errors. Top adjudication errors were provider ID, COB, procedure service unit, and duplicate errors. There were also several hundred transactions rejected which were subsequently corrected in the Transaction Insight Tool by the plans.

First Encounter cycle - 736 files, total encounters = 3,045,356, good encounters = 2,451,183, encounters with errors = 594,173.

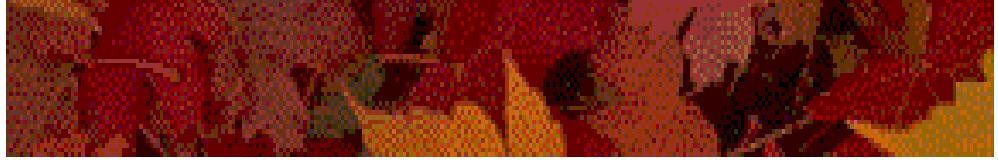
Second Encounter cycle - 482 files, total encounters = 1,353,335, good encounters = 1,347,908, encounters with errors = 5,427.

While an implementation that is hiccup free is rare, we were pleased that overall these implementations went well and any noted concerns were quickly and efficiently addressed, and we appreciate both internal and external cooperation in these efforts.



Transplant Stage Invoices Returned When no Encounters have been reported

The AHCCCS Reinsurance unit will no longer process Transplant Stage Invoices when the stage services have not been encountered. Based on the provider's claims submitted with each stage please insure all were encountered prior to the submission or re-submission of the Transplant Stage Invoice. The Stage Invoices will be stamped with the date of receipt and returned to the Contractor. For those stages returned it will be necessary for the submitter to monitor the PMMIS transplant stage for associated encounters. At this time, we will base timely filing on the original submission date stamped on the returned stage. We will not track these returned stages making it imperative that you return the original when all claims have been encountered.



Use of 59 Modifier

It was recently identified that Reinsurance was not pulling over all encountered modifiers resulting in pends to our Contractors. During the correction process, we also researched the usage of specific modifiers for appropriateness. Dr. Leib, AHCCCS Chief Medical Officer, recently wrote the attached memo for distribution to our AHCCCS providers in an effort to explain the proper usage of Modifier 59. With Dr. Leib's permission, it is included for your review and reference.

DATE: July 10, 2007

TO: AHCCCS Providers

FROM: Marc Leib, M.D., Chief Medical Officer

SUBJECT: Use of the -59 Modifier with the Hydration, Infusion and Injection CPT Codes

ISSUE

Can a “-59” modifier be added to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes describing hydration, infusion and injection services to obtain separate and additional reimbursements when those services are provided to an AHCCCS member in the hospital Emergency Department (ED)?

BRIEF ANSWER

No, a “-59” modifier cannot be appended to CPT or HCPCS codes describing hydration, infusion or injection services to differentiate them from the underlying professional evaluation and management (E/M) services provided by ED physicians. Similarly, this modifier cannot be used on hospital claims to identify those services for additional hospital reimbursement purposes.

EXPLANATION

Background

AHCCCS has recently received several complaints from physicians and hospitals regarding the bundling of CPT codes describing hydration, infusions and injections (90760-90775, hereafter collectively referred to as “IV codes”) into the E/M codes describing hospital Emergency Department (ED) services. While these complaints involved specific codes, there appears to be some general confusion over the proper use of the -59 modifier (“Distinct Procedural Service”). This memo provides general information regarding the use of the -59 modifier and addresses the specific concerns raised by some providers regarding the use of the -59 modifier with IV codes. The Centers for Medicare and Medicaid Services recently published information regarding the proper use of the -59 modifier that may be of additional value.¹

General Use of the -59 Modifier

The National Correct Coding Initiative (NCCI) edits define pairs of CPT or HCPCS codes that may not be reported together except under special circumstances. When those circumstances exist, the two codes may both be reported and the -59 modifier attached to one of the codes to indicate that in that particular case, the service was distinct and independent from other services performed on the same day.

According to CMS, appropriate uses of the -59 modifier include situations when the service normally bundled into the other service was performed during a different patient encounter on the same day, on a different anatomic site or organ system, on a separate lesion, through a separate incision or excision, or due to a separate injury. For purposes of the NCCI edits, the definition of “different anatomic site” includes a different organ (even if in the same general anatomic region) or different lesions in the same organ, but it does not include treatment of contiguous structures in the same organ. Anatomically contiguous areas are not considered different anatomic sites for the purpose of using the -59 modifier. For example, repairing an injury to the nail, nail bed and the surrounding structures on the **same digit** cannot be billed using separate CPT codes and the -59 modifier. Repair of a nail bed on one digit and the tissues surrounding the nail bed **on another digit** may be billed using the -59 modifier to indicate that the second procedure was performed on a separate anatomic area. As a further example, the posterior structures in the eye constitute a single anatomic site, even if treatment included procedures on several posterior segment structures.

According to CMS, another source of confusion regarding the use of the -59 modifier is that it is sometimes used to describe a “different procedure or surgery.” By definition, different CPT/HCPCS codes describe different procedures or surgeries. If two codes are listed among the code pairs on the NCCI edits, bundling cannot be negated by the use of the -59 modifier if the services were performed at the same anatomic site during the same patient encounter. When the services are performed on a different anatomic site **or** during a different patient encounter on the same day, the normally bundled code may be billed separately with the -59 modifier.

In addition to listing bundled code pairs, the NCCI indicates whether the two codes may ever be listed with a -59 modifier. An indicator of “0” means that there are no circumstances that would allow the two codes to be listed together, even with the -59 modifier. An indicator of “1” means that under the proper circumstances the two codes may both be listed and the -59 modifier used. An indicator of “1” does not mean that the -59 modifier can be attached whenever the two codes appear on a single claim. If the two services were not provided during a separate patient encounter or performed on a different anatomic site, the -59 modifier may not be used and only one of the two codes may be included on the claim. Documentation supporting the separate

¹ CMS MLN Matters, Number SE0715, *Proper Use of Modifier “-59”*

patient encounter or different anatomic site may be required to support the use of the -59 modifier.

Use of the -59 Modifier with Hydration, Infusion or Injection Services Provided in Hospital Emergency Departments

The American Medical Association recently modified CPT codes describing hydration, infusions and injections (90760-90775, hereafter collectively referred to as “IV codes”) and CMS has deleted several HCPCS codes describing these services, cross-walking those deleted codes to the existing CPT codes. The NCCI pairs these CPT codes with ED E/M codes (99281-99285). Therefore, except in unusual circumstances, the IV codes cannot be separately claimed when the treatment is provided as part of the ED visit. In fact, the NCCI pairs the IV codes with all E/M codes, including hospital, office, consultations, nursing facilities and other types of E/M services.

According to the AMA CPT Manual, the “levels of E/M services include examinations, evaluations, **treatments**, conferences with or concerning patients,” The CPT Manual also states that the “levels of E/M services encompass the wide variations, in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and **treatment** of illness or injury and the promotion of optimal health.” The NCCI code pairs identify those services that are generally considered to be “bundled” into the E/M codes, including the IV codes.

Furthermore, CMS defines the IV codes as “incident to” codes, which identifies services included as part of the underlying physician service when provided by auxiliary personnel working under the physician’s supervision. Medicare does not make any separate payments for those services when they are provided to hospital inpatients or patients in a hospital outpatient department. AHCCCS follows similar policies.

In rare situations, services described by one of the IV codes may be claimed with a -59 modifier to override the NCCI edits. One possible scenario is if the ED physician evaluates and/or treats a patient and the patient is discharged from the ED. Later that same day the patient returns and **without charging another ED E/M visit code**, the physician orders an IV infusion for hydration. Under that scenario, the hydration service was provided at a different patient encounter than the original E/M services and may be identified with the -59 modifier. If, however, the ED physician claims an E/M service for the second visit, the hydration therapy would be bundled into that second E/M code.

Similarly, hospital payments under the AHCCCS Outpatient Fee Schedule for ED services (usually described by Rev Code 450) include the services described by the IV codes. Thus, neither claims for professional services provided in the ED nor hospital claims for ED services should include separate hydration, infusion or injection services in the usual ED circumstances. If, in extraordinary circumstances the hospital or ED physicians believe these services satisfy the requirements for a separate claim, documentation should be submitted supporting that claim.